

		FOR OHF USE					

LL 1

**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0044859</u></p> <p><b>Facility Name:</b> <u>Wauconda Healthcare and Rehab</u></p> <p><b>Address:</b> <u>176 Thomas Court</u> <u>Wauconda</u> <u>60084</u>          Number City Zip Code</p> <p><b>County:</b> <u>Lake</u></p> <p><b>Telephone Number:</b> <u>(847) 526-5551</u> <b>Fax #</b> <u>(847) 526-0807</u></p> <p><b>IDPA ID Number:</b> <u>36 - 4343848</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>1-May-2000</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Christopher Vicere</u> <b>Telephone Number:</b> <u>(773) 604-8112</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>5/1/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1150 678 1283 829" rowspan="2"><b>Officer or Administrator of Provider</b></td> <td data-bbox="1283 678 1921 727">(Signed) _____ <u>30-March-2001</u> (Date)</td> </tr> <tr> <td data-bbox="1283 727 1921 808">(Type or Print Name) <u>Christopher Vicere</u> (Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td data-bbox="1150 829 1283 1040" rowspan="4"><b>Paid Preparer</b></td> <td data-bbox="1283 829 1921 878">(Signed) _____ (Date)</td> </tr> <tr> <td data-bbox="1283 878 1921 938">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1283 938 1921 1008">(Firm Name &amp; Address) _____</td> </tr> <tr> <td data-bbox="1283 1008 1921 1040">(Telephone) <u>( )</u> Fax # ( )</td> </tr> </table> <p align="center"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ <u>30-March-2001</u> (Date)	(Type or Print Name) <u>Christopher Vicere</u> (Title) <u>Chief Financial Officer</u>	<b>Paid Preparer</b>	(Signed) _____ (Date)	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>( )</u> Fax # ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																															
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																															
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	(Telephone) <u>( )</u> Fax # ( )																																

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Wauconda Healthcare and Rehab# 0044859 Report Period Beginning: 5/1/00 Ending: 12/31/00

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)	<u>117</u>	<u>28,665</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		TOTALS	<u>117</u>	<u>28,665</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>11,208</u>	<u>2,008</u>	<u>1,766</u>	<u>14,982</u>	8
9	SNF/PED					9
10	ICF	<u>7,100</u>	<u>3,613</u>		<u>10,713</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,308</u>	<u>5,621</u>	<u>1,766</u>	<u>25,695</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 89.64%

D. How many bed-hold days during this year were paid by Public Aid?

18 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 1-May-2000

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 1-May-2000NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 26

and days of care provided

1,661Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐

Tax Year:

Fiscal Year:

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

Wauconda Healthcare and Rehab

# 0044859

Report Period Beginning:

5/1/00

Ending:

12/31/00

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	161,759	10,409	12,653	184,821		184,821		184,821			1
2	Food Purchase		113,213		113,213	(7,644)	105,569	(237)	105,332			2
3	Housekeeping	119,548	23,860	3,542	146,950		146,950		146,950			3
4	Laundry	31,467	15,277	8,422	55,166		55,166		55,166			4
5	Heat and Other Utilities			61,044	61,044		61,044		61,044			5
6	Maintenance	27,756	23,846	21,165	72,767		72,767		72,767			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	340,530	186,605	106,826	633,961	(7,644)	626,317	(237)	626,080			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			5,950	5,950		5,950		5,950			9
10	Nursing and Medical Records	1,215,938	58,601	53,676	1,328,215		1,328,215		1,328,215			10
10a	Therapy			19,227	19,227		19,227		19,227			10a
11	Activities	44,637	5,130	454	50,221		50,221		50,221			11
12	Social Services	21,338		2,759	24,097		24,097		24,097			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,281,913	63,731	82,066	1,427,710		1,427,710		1,427,710			16
	<b>C. General Administration</b>											
17	Administrative	46,638		120,485	167,123		167,123	(80,505)	86,618			17
18	Directors Fees											18
19	Professional Services			20,973	20,973		20,973	2,029	23,002			19
20	Dues, Fees, Subscriptions & Promotions			37,555	37,555		37,555	(23,086)	14,469			20
21	Clerical & General Office Expenses	108,334	29,527	23,961	161,822		161,822	37,357	199,179			21
22	Employee Benefits & Payroll Taxes			211,512	211,512	7,644	219,156	2,351	221,507			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,404	5,404		5,404	570	5,974			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			30,624	30,624		30,624		30,624			26
27	Other (specify):* Auto. Expense			394	394		394	3,882	4,276			27
28	<b>TOTAL General Administration</b>	154,972	29,527	450,908	635,407	7,644	643,051	(57,402)	585,649			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,777,415	279,863	639,800	2,697,078		2,697,078	(57,639)	2,639,439			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name & ID Number      Wauconda Healthcare and Rehab      #0044859      Report Period Beginning:      5/1/00      Ending:      12/31/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			2,938	2,938		2,938	146	3,084			30
31	Amortization of Pre-Op. & Org.							1,934	1,934			31
32	Interest			19,980	19,980		19,980	297,336	317,316			32
33	Real Estate Taxes			36,664	36,664		36,664		36,664			33
34	Rent-Facility & Grounds			440,000	440,000		440,000	(177,687)	262,313			34
35	Rent-Equipment & Vehicles			7,899	7,899		7,899		7,899			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			507,481	507,481		507,481	121,729	629,210			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,903	42,750	97,653		97,653		97,653			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			42,998	42,998		42,998		42,998			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		54,903	85,748	140,651		140,651		140,651			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,777,415	334,766	1,233,029	3,345,210		3,345,210	64,090	3,409,300			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **Wauconda Healthcare and Rehab**# **0044859**

Report Period Beginning:

**5/1/00**

Ending:

**12/31/00****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer-</b>	<b>OHF USE</b>	
			<b>ence</b>	<b>ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(31)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(237)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(24,164)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (24,432)		\$	30

<b>OHF USE ONLY</b>						
48		49	50	51	52	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	88,522		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 88,522		36
37	<b>(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 64,090		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Wauconda Healthcare and Rehab

ID# 004859

Report Period Beginning: 5/1/00

Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1	\$	1
2		2
3		3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
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83		83
84		84
85		85
86		86
87		87
88		88
89		89
90 Total	0	90

## Summary A

12/31/00

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[illegible]

## Summary B

Facility Name & ID Number	Wauconda Healthcare and Rehab	#	0044859	Report Period Beginning:	5/1/00	Ending:	12/31/00
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## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name &amp; ID Number      Wauconda Healthcare and Rehab

#      0044859

Report Period Beginning:

5/1/00

Ending:

12/31/00

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	17	Salary - Cynthia and Laurence	\$	Lancaster, Ltd.	100.00%	\$ 26,077	\$ 26,077	1
2	V	27	P/R Taxes-Cynthia and Laurence		Lancaster, Ltd.	100.00%	728	728	2
3	V	17	Management Fee Income	112,000	Lancaster, Ltd.	100.00%		(112,000)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	2,029	2,029	4
5	V	21	Office Expenses		Lancaster, Ltd.	100.00%	2,333	2,333	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	2,351	2,351	6
7	V	24	Education and Seminars		Lancaster, Ltd.	100.00%	570	570	7
8	V	17	Aministrative Consultant		Lancaster, Ltd.	100.00%	5,418	5,418	8
9	V	32	Interest	23,345	Lancaster, Ltd.	100.00%	23,595	250	9
10	V	30	Depreciation		Lancaster, Ltd.	100.00%	146	146	10
11	V	21	Salaries - Clerical		Lancaster, Ltd.	100.00%	35,024	35,024	11
12	V	27	P/R Taxes - Clerical		Lancaster, Ltd.	100.00%	3,154	3,154	12
13	V	20	Advertising		Lancaster, Ltd.	100.00%	1,078	1,078	13
14	Total			\$ 135,345			\$ 102,503	\$ * (32,842)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

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Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 5/1/00 Ending: 12/31/00

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Cynthia Chow	Officer	Administrative	33.34%	See Attached	2	3.00%	Lancaster	\$ 11,077	17-7	1
2	Laurence Zung	Officer	Administrative	33.33%	See Attached	2	4.17%	Lancaster	15,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 26,077		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Wauconda Healthcare and Rehab# 0044859

Report Period Beginning:

5/1/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Lancaster, Ltd.Street Address 3520 W. Thorndale Ave.City / State / Zip Code Chicago, IL . 60659Phone Number ( 773) 539-8181Fax Number ( 773) 539-8133

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Cynthia Chow	Hours Worked	65	7	\$ 360,000	\$ 360,000	2	\$ 11,077	1
2	27	Cynthia Chow	Hours Worked	65	7	10,054	0	2	309	2
3	17	Laurence Zung	Hours Worked	48	7	360,000	360,000	2	15,000	3
4	27	Laurence Zung	Hours Worked	48	7	10,054	0	2	419	4
5										5
6										6
7	19	Professional Services	Management Fees	1,455,000	7	26,361	0	112,000	2,029	7
8	21	Office Expenses	Management Fees	1,455,000	7	30,313	0	112,000	2,333	8
9	22	Employee Benefits	Management Fees	1,455,000	7	30,548	0	112,000	2,351	9
10	24	Education and Seminars	Management Fees	1,455,000	7	7,408	0	112,000	570	10
11	17	Administrative Consultant	Management Fees	1,455,000	7	70,392	0	112,000	5,418	11
12	32	Interest	Management Fees	1,455,000	7	306,522	0	112,000	23,595	12
13	30	Depreciation	Management Fees	1,455,000	7	1,898	0	112,000	146	13
14	21	Salaries - Clerical	Management Fees	1,455,000	7	454,998	454,998	112,000	35,024	14
15	27	P/R Taxes Clerical	Management Fees	1,455,000	7	40,971	0	112,000	3,154	15
16	20	Advertising	Management Fees	1,455,000	7	14,009	0	112,000	1,078	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,723,528	\$ 1,174,998		\$ 102,503	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	American National Bank		X	Working Capital	Interest Only				Demand	Prime	19,980	6	
7	Wauconda Associates	X									297,117	7	
8	Lancaster Allocation	X									23,345	8	
9	TOTAL Facility Related						\$	\$			\$ 340,442	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 340,442	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Wauconda Healthcare and Rehab**# **0044859** Report Period Beginning: **5/1/00** Ending: **12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	36,664	2
3. Under or (over) accrual (line 2 minus line 1).	\$	36,664	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	36,664	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8		
	1996	9		
	1997	10		
	1998	11		
	1999	54,589	12	

	<b>FOR OFF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 B. General Construction Type:
 Exterior
 Brick
 Frame
 Number of Stories

C. Does the Operating Entity?
 (a) Own the Facility
 (b) Rent from a Related Organization.
 (X) (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (X) (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 (X) YES
 NO

If so, please complete the following:

1. Total Amount Incurred:
 14,507
 2. Number of Years Over Which it is Being Amortized:
 5

3. Current Period Amortization:
 1,934
 4. Dates Incurred:
 1 - May - 2000

Nature of Costs:
 Organization costs associated with the purchase of the facility.

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

12/31/00

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$	\$	\$	\$		\$	37
38	Current Year Purchases	20,884	3,012	3,012		20	3,012	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 20,884	\$ 3,012	\$ 3,012	\$		\$ 3,012	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 23,746	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 3,084	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 3,084	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 3,084	51

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Wauconda Associates \*\*\*an unrelated entity\*\*\*

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>262,313</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>262,313</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 7,899 Description: Laundry Washing Machine \$1940, Copier \$4204, Wheelchair Washer \$1755

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 1 - May - 2000

Ending 30 - April - 2007

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ 426,259

13. /2002 \$ 429,240

14. /2003 \$ 429,240

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 16,818
2	Licensed Speech and Language Development Therapist	39-3	hrs				2,722			2,722	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				23,210			23,210	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					27,012		27,012	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): *Med Sup/Sp. Bed Ren	39-2						27,891		27,891	13
14	TOTAL			\$		\$ 42,750	\$ 54,903		\$ 97,653	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 10,744	\$ 10,744	1
2	Cash-Patient Deposits	39,376	39,376	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,025,716	1,025,716	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,151	32,151	6
7	Other Prepaid Expenses	6,750	6,750	7
8	Accounts Receivable (owners or related parties)	351,433	411,248	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,466,170	\$ 1,525,985	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,862	2,862	15
16	Equipment, at Historical Cost	20,884	20,884	16
17	Accumulated Depreciation (book methods)	(2,938)	(2,938)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		14,507	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,934)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <b>*Option Deposit*</b>		3,600,000	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 20,808	\$ 3,633,381	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,486,978	\$ 5,159,366	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 91,117	\$ 91,117	26
27	Officer's Accounts Payable	1,050,000	1,050,000	27
28	Accounts Payable-Patient Deposits	39,376	39,376	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	267,156	267,156	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,942	28,942	31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,664	36,664	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,513,255	\$ 1,513,255	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		3,793,752	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 3,793,752	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,513,255	\$ 5,307,007	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (26,277)	\$ (147,641)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,486,978	\$ 5,159,366	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(26,277)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (26,277)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (26,277)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,338,037	1
2	Discounts and Allowances for all Levels	(215,700)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,122,337	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	120,599	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 120,599	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	32,227	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,541	19
20	Radiology and X-Ray	29,474	20
21	Other Medical Services	10,724	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 75,966	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	31	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 31	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,318,933	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	633,961	31
32	Health Care	1,427,710	32
33	General Administration	635,407	33
	<b>B. Capital Expense</b>		
34	Ownership	507,481	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	97,653	35
36	Provider Participation Fee	42,998	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,345,210	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(26,277)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (26,277)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. \*Cash Basis Taxpayer

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Wauconda Healthcare and Rehab**# **0044859**Report Period Beginning: **5/1/00**Ending: **12/31/00****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,064	1,107	\$ 34,115	\$ 30.82	1
2	Assistant Director of Nursing	1,841	2,118	54,253	25.62	2
3	Registered Nurses	15,772	17,687	416,246	23.53	3
4	Licensed Practical Nurses	4,683	5,014	97,681	19.48	4
5	Nurse Aides & Orderlies	48,061	51,967	595,682	11.46	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,237	1,397	20,447	14.64	9
10	Activity Assistants	2,473	2,597	24,190	9.31	10
11	Social Service Workers	1,873	1,911	21,338	11.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,714	16,013	161,759	10.10	15
16	Dishwashers					16
17	Maintenance Workers	2,391	2,691	27,756	10.31	17
18	Housekeepers	11,769	12,508	119,548	9.56	18
19	Laundry	3,844	3,960	31,467	7.95	19
20	Administrator	1,341	1,394	46,638	33.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,793	5,521	108,334	19.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,471	1,507	17,961	11.92	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	117,327	127,392	\$ 1,777,415 *	\$ 13.95	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	316	\$ 12,653	1-3	35
36	Medical Director	153	5,950	9-3	36
37	Medical Records Consultant	60	2,352	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	25	440	10-3	39
40	Physical Therapy Consultant	376	19,227	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	454	11-3	44
45	Social Service Consultant	72	2,759	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,014	\$ 43,835		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,777	\$ 50,884	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,777	\$ 50,884		53

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Arleene Wajda	Administrator	N/A	\$ 46,638
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 46,638
B. Administrative - Other			
Description			Amount
Management Fees - Lancaster			\$ 112,000
Administrative Consultant			8,485
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 120,485
C. Professional Services			
Vendor/Payee	Type		Amount
Health Data Systems	Data Processing		\$ 18,566
IIT / Sourcetech	Data Processing		645
Computer Business Services	Data Processing		1,377
Personnel Planners	Unemployment Tax Consult		385
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 20,973
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 13,130
Unemployment Compensation Insurance			12,782
FICA Taxes			125,150
Employee Health Insurance			42,992
Employee Meals			7,644
Illinois Municipal Retirement Fund (IMRF)*			
***Misc. Employee Benefits***			8,205
***Retirement Plan Contribution***			9,253
***Lancaster Allocation***			2,351
TOTAL (agree to Schedule V, line 22, col.8)			\$ 221,507
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 150
Advertising: Employee Recruitment			9,589
Health Care Worker Background Check (Indicate # of checks performed 7 )			105
***Advertising & Promotions***			23,086
***Licenses & Fees***			408
***Dues & Subscriptions***			4,217
***Lancaster Allocation***			1,078
Less: Public Relations Expense			(23,086)
Non-allowable advertising			(1,078)
Yellow page advertising			( )
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 14,469
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			1,548
Seminar Expense			3,856
***Lancaster Allocation***			570
Entertainment Expense			( )
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 5,974

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number **Wauconda Healthcare and Rehab**

STATE OF ILLINOIS

# **0044859**

Report Period Beginning:

**5/1/00**

Ending:

Page 23

**12/31/00**

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council on Long-Term Care = \$3500
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,598 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 42,998  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 7,644 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.